Depression and Dysphoria Among the Elderly: Dispelling a Myth

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In 1978, the President's Commission on Mental Health reported that "depression escalates decade by decade."[1] Butler and Lewis[2] in 1977 likewise had stated that "depression in particular rises with age." Cultural, social, and psychological perspectives have been used to explain this phenomenon of increasing dysphoria in old age. Major life changes accompany the later years and include loss of friends and family through death or relocation, loss of health, increasing disability and dependence, and loss of useful social roles, among others. The stresses resulting from such losses would appear to provide the ideal environment in which depression and dissatisfaction might flourish.[3] Indeed, such reasoning appears to be well substantiated by results of earlier epidemiologic studies of psychopathology among the aged. National surveys conducted by the National Institute of Mental Health (NIMH) in the 1950s reported the following prevalence estimates for psychiatric disorders in the general population by age: 25 to 34 years, 76.3 per 100,000; 35 to 64 years, 93.0 per 100,000; 65 years and over, 235.1 per 100,000.[4] A later study by Gianturco and Busse[5] added further support to the earlier findings of increasing psychopathology with age. In their study of depressive illness in 264 normal elderly volunteers followed over a 20-year period, these investigators reported that nearly 70 percent of their subjects experienced one or more episodes of depression.

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While reports appeared claiming prevalence rates of up to 44 percent for depressive symptoms in elderly populations, other studies reported rates of less than 5 percent.[6-8] When major affective disorders were differentiated, rates as low as 1 to 3 percent were encountered.[9] These disparities in estimates of distress, at least in part, may be explained by broad methodological variations between studies.[10] Subjects were rarely selected using random probability sampling; rather, convenience samples or volunteers were often utilized. Measurement instruments have likewise varied widely, ranging from self-report symptom checklists to structured and unstructured psychiatric interviews.[11] Major depression and less severe types of dysphoria were not always differentiated. Depression is not a single entity but a continuum of symptoms ranging from feelings of dissatisfaction to a severe, life-threatening psychiatric illness. Until recently, criteria for diagnosis and differentiation of various grades of depression and separation of these from organic brain syndromes were vague and poorly defined.[11] The development of the *Diagnostic and Statistical Manual of Mental Disorders*[12] in 1978-1980 represented a major step in providing standardized operational criteria for psychiatric diagnoses. Affective disorders were divided into major depression and dysthymia, each characterized by clearly defined features.

Blazer and Williams[11] were the first to utilize DSM III criteria for major depression and dysthymia in a study examining the prevalence of affective disorders in a sample of 997 community dwelling elderly. They reported the combined rate of dysphoric symptoms in this population to be 14.7 percent. This figure included rates of 4.5 percent for dysphoric symptoms only, 6.5 percent for depressive symptoms associated with impaired health, and 3.7 percent for major depression (1.8 percent for primary depression, 1.9 percent for secondary). They did not differentiate rates of depression in young-old and old-old subgroups of their eld-

erly sample, nor did they include groups aged less than 65 years for comparison of prevalence rates.

Eaton and Kessler,[13] however, did examine rates of depressive symptoms in younger and older populations. As their measurement instrument, they used the Center for Epidemiologic Studies Depression Scale (CES-D), which, while incapable of clearly differentiating major depression from less severe forms of dysphoria, is an instrument of established reliability and validity.[14] Surveying 2,867 persons aged 25 to 74 years, of which 11.8 percent were over 65 years, they found rates of depressive symptoms to be nearly three times more frequent in subjects less than 45 years old as compared with those over 65 years (18 percent and 6 percent, respectively). In a recent study of community-dwelling elderly, Feinson and Thoits,[10] using the Johns Hopkins Symptom Checklist,[15] have likewise found lower rates of depressive symptomatology (5.1 to 11.5 percent) among elderly subjects than previously reported.

Within the past five years, the NIMH has conducted a large five-site epidemiologic study examining the prevalence of psychiatric disorders in the community. Analysis of data from three of these sites has been reported.[16] This study has been claimed by some to "provide a data bank for community-based older adults unsurpassed in the world."[17] A standardized structured interview, the Diagnostic Interview Schedule,[18] was utilized by trained interviewers to survey 9,500 randomly selected subjects of all ages. Analysis of data for 923 elderly subjects at the Baltimore site has uncovered rates of major depression and dysthymia that are significantly lower than those found for younger age groups.[19]

This NIMH survey is also the first wide-scale epidemiologic study that examined depressive symptoms in age-divided subgroups of older persons. Persons over the age of 65 years are a tremendously diverse group spanning an age range of more than 30 years. Too often earlier studies lump this group together into a single unit for discussion. Available data from these more recent studies suggest that there is some increase in dysphoria among the old-old or individuals aged over 75 years. The NIMH study noted above found nearly double the rate of major depression in the over 75 year age group compared with the 65- to 74-year age group (1.3 percent and .7 percent, respectively). Both older age groups, however, had lower rates than the 18- to 64-year-olds (2.5 percent). Less severe dysthmic disorders were only slightly more frequent among those aged over 75 years (1.1 percent) compared with that in the 65- to 74-year age group (1.0 percent), and both were again less than that in the younger subjects (2.3 percent). Feinson and Thoits[10] also found a significant increase in psychological distress with age within their older population, though the relationship with age was extremely weak.

Some investigators have reported that a four-fold increase in admission to mental hospitals occurs between the ages of 75 and 80 years, with a continued steep increase thereafter to the age of 85 years. These admissions, rather than representing psychopathology, are due to the increasing incidence of organic brain syndromes with age. Forty percent of elderly residents and nearly two thirds of elderly admissions in long-stay psychiatric facilities have a primary diagnosis of dementia.[20]

It is not clear why the elderly (as a group) appear to suffer less psychopathology than their younger counterparts.[21] Whether the elderly perceive major life changes as less stressful or whether they possess unusually effective coping behaviors is a topic of ongoing research.[22] At a time in life when stressful life changes are most intense, with loss being the predominant theme, depressive symptoms and dissatisfaction with life appear to be less frequent than during any other period.

Hence, current data from recent epidemiologic studies do not support the prevalent myth that mental illness rises with increasing age. In contrast, there appears to be greater support for a decrease in frequency of mental disorders among older persons and an increased ability to cope with major life changes when compared with younger age groups. Indeed, it may be to our elders that we must turn in the search for effective ways of handling life's crises.

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